Dermatology Professional Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

Applies to the following Tufts Health Public Plans products:

- ☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracted providers who render dermatology services.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional and Facility Services Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary dermatology services, in accordance with the member's benefit.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Dermatology services that have been determined to be cosmetic, experimental, or investigational are not covered.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained.

Commercial and Tufts Health Public Plans

Certain covered services may require prior authorization for Commercial and Tufts Health Public Plans members. Refer to the medical necessity guidelines for Reconstructive and Cosmetic Surgery for more information.

Dermatological transgender services may be authorized when medical necessity criteria are met. Refer to the Transgender Surgical Procedures medical necessity guidelines for Commercial and Tufts Health Direct and Tufts Health Together, Tufts Health RITogether and Tufts Health Unify for more information.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO
A specialist referral is required for dermatology services.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan accepts all industry standard codes. Refer to current industry standard resources for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the Professional Services and Facilities Payment Policy.

Wound Repair
If a simple repair procedure code (12001, 12002) or an intermediate repair procedure code (12031,12032) is billed with a complex repair procedure code (13101, 13121) for the same wound site, then the simple repair procedure code or repair intermediate procedure code will deny, as these services are included in the complex repair procedure code. Refer to the AMA CPT Manual for additional information. Tufts Health Plan will consider compensation if the appropriate modifier is appended to the simple repair or intermediate repair procedure code.

ADDITIONAL RESOURCES

Bilateral and Multiple Surgical Procedures Payment Policy
Evaluation and Management Professional Payment Policy
Laboratory and Pathology Payment Policy
Noncovered Investigational Services Medical Necessity Guidelines
Surgery Professional Payment Policy

DOCUMENT HISTORY

- September 2020: Policy reviewed by committee; added Tufts Health Public Plans; template updates
- June 2018: Template updates
- March 2018: Policy reviewed by committee; added transgender procedures language
- January 2017: Template updates
- September 2015: Template conversion
- April 2015: Added Tufts Medicare Preferred HMO and Tufts Health Plan SCO; template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members.

This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.